

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Too many ethical committees

SIR,—The Medical Research Council and other bodies funding research require that ethical approval is obtained from each health authority whose residents might be affected. This has complicated the initiation of large epidemiological and multicentre studies. To continue our programme of anonymous screening of routinely collected neonatal blood samples for HIV¹ we recently sought ethical permission from the 43 districts in three Thames regions. The following observations may assist others embarking on a similar course.

We had already gained ethical approval from the committees based at the Hospital for Sick Children and the Institute of Child Health and from Merton Health Authority because these committees covered the relevant neonatal screening laboratories. In March 1990 the same protocol together with the letter of approval and a copy of the paper reporting our earlier findings¹ were sent to the 43 districts. A covering letter explained that we wished to begin the project as soon as possible, subject to approval.

We found that the names and addresses of chairs of ethical committees were not readily available: 18 districts provided incorrect information. (The Royal College of Physicians list contains many of the same errors. Also, it gives 52 ethical committees for 41 districts and none for the remaining two.)

Of the districts, three had more than one ethical committee that wanted to review the proposal, seven requested extra copies of the submission, five wanted their own application forms to be filled in, and five wanted a principal investigator to attend a meeting, spending a half day to give a three minute presentation.

Twenty two districts had to be prompted to respond, and 10 needed five or more telephone calls. One has only just given written approval, although we understand that all members of the committee individually approved the plan some months ago. Another has not even acknowledged our submission despite repeated efforts.

Although we are aware that research into HIV infection raises sensitive issues, this caused delay in only seven districts. These issues were easily resolved in all but two cases. Most problems were administrative: many ethical committees have no clear procedure and no regular meetings.

The problems that we encountered would be much worse if a national study was undertaken. In addition to time spent the cost of obtaining approval from every district must also be considered. The average cost, including photocopying, postage, telephone calls, travel, and time of clerical and senior staff was £20.41 per district. The total cost was £939. A study covering England and Wales would therefore cost about £4000. It is unlikely that this could be charged retrospectively to grant funding bodies.

A far better solution for multicentre epidemiological studies would be a national coordinating committee as proposed by the *BMJ*^{2,3} and the Royal College of Physicians.⁴ Protocols for projects approved at national level could be forwarded to the local ethical committees concerned, who would be able to "opt out." This would make researchers less vulnerable to bureaucratic whims, while giving each district the chance to refuse to participate in research programmes that they believed were unethical.

Though there is no shortage of guidelines for ethical committees,⁴ now that so many may have to be consulted for one project some mechanism is needed to ensure that one (and only one) ethical committee in each district has the task of over-viewing multicentre applications and that clear cut procedures are followed.

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- 1 Peckham CS. Prevalence of maternal HIV infection based on unlinked anonymous testing of newborn babies. *Lancet* 1990;335:516-9.
- 2 Lock S. Monitoring research ethical committees. *BMJ* 1990;300:61-2. (13 January.)
- 3 Lock S. Towards a national bioethics committee. *BMJ* 1990;300:1149-50. (5 May.)
- 4 Royal College of Physicians. *Guidelines on the practice of ethics committees in medical research involving human subjects*. 2nd ed. London: RCP, 1990.

Cross contamination of bronchial washings

SIR,—Inadequate cleansing and disinfection of fiberoptic bronchoscopes with combined suction channel and biopsy port valves have resulted in cross infection or cross contamination with mycobacteria, including *Mycobacterium tuberculosis* and *M. avium*.¹ We report an episode of contamination of a flexible fiberoptic bronchoscope with a strain of *M. chelonai*.

Over two weeks we found acid fast bacilli in bronchial washings from four patients at risk of mycobacterial disease: one had bronchiectasis and three had disease conforming to the World Health Organisation definition of AIDS.² Standard antituberculous treatment was started. We were suspicious that a cluster of four aspirates should contain acid fast bacilli. The patients had been investigated with the same bronchoscope, which was a new design to the hospital, and, unfortunately, an instruction manual had not been supplied. The bronchoscope had been used once before the acid fast bacilli were found and had been cleaned and disinfected according to the protocol agreed by the hospital control of infection committee, in accordance with the British Thoracic Society guidelines.³

The protocol allowed tap water, a source of environmental mycobacteria,⁴ to be used to make up detergent and for final rinsing. Despite using sterile water instead of tap water the next bronchial washing contained acid fast bacilli. Examination of the suction channel activator valve, which had not been dismantled previously, showed an accumulation of organic debris containing acid fast bacilli. This was cultured. A spare suction valve and instruction manual were then obtained. Despite dismantling, manual cleaning, ultrasonication, and separate disinfection of the suction activator valve, the next bronchial washing also contained acid fast bacilli. The contamination problem was solved only after even more stringent cleaning of the suction activator valve, including removing the O ring followed by ultrasonication and autoclaving.

The same strain of *M. chelonai* was isolated from bronchial washings of two patients, the detergent container, suction channel washings, and debris on the suction valve. It was not recovered from the biopsy channel, its valve, or the detergent. Other environmental mycobacteria were recovered from deposits of tap water. There is no evidence that *M. chelonai* was transmitted to any patient.

This episode highlights the importance of regular reviewing and updating of protocols in line with design modifications of bronchoscopes. The manufacturer's instruction manual should list heat resistant removable components that should be sterilised by autoclaving. The use of tap water throughout the decontamination process must be questioned. Staff purchasing endoscopes should discuss disinfection procedures with the control of infection officer and doctors before purchasing.

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- 1 Wheeler PW, Lancaster D, Kaiser AB. Bronchopulmonary cross colonization and infection of suction valves of bronchoscopes. *J Infect Dis* 1989;159:954-8.
- 2 World Health Organisation. Acquired immunodeficiency syndrome (AIDS). *Weekly Epidemiological Record* 1986;61:334-9.
- 3 Woodcock A, Campbell I, Collins JVC, et al. Bronchoscopy and infection control. *Lancet* 1989;ii:270-1.
- 4 Collins CH, Grange JM, Yates MD. Mycobacteria in water. *J Appl Bacteriol* 1984;57:193-211.

BCG vaccination in children

SIR,—Dr S P Conway recommends that neonates born in urban priority areas should be offered BCG vaccination.¹ Our recent experience in two areas supports the widespread adoption of such a policy.